DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

Ľ,	J	1.5.		$\widetilde{\mathbb{W}}$	[FILE]	
F	لعط	2	ļ	200	17	

**[2]** 004

PRINTED: 01/30/2007 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) M		BE/CONSTRUCTION	(X3) DATE SI COMPLE	
		09G166	B. WIN	IG _			R 5/2007
	ROVIDER OR SUPPLIER		<b>★</b>	6	REET ADDRESS, CITY, STATE, ZIP CO 917 MAPLE ST NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
(W 000)	2007 to verify con Participation of CI Treatment previous compliance on De with varying degree facility. Three of the selected for the selected facilities for person persons with related to the provide health or mentally retarded related conditions (2) The institution E of Part 442 of the condition of the selected for the selec	was conducted on January 25, appliance with the Conditions of ient Protections and Active usly determined to not be in accember 14, 2006. Six females are of disability reside in the the six clients were randomly ample. The findings of the don observations at the group of programs, interviews with staff are review of records including the made some progress, it was are Conditions of Participation in ment and Client Protections had accepted to as intermediate care as with mental retardation) or ed conditions if; arpose of the institution is to rehabilitative services for individuals or persons with meets the standards in Subpart also Chapter; and etarded recipient for whom sted is receiving active	(W 0		TILE		(X6) DATE
	Lymey	Styph			President	<u></u> .	2/20/

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whather or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M			(X3) DATE SU COMPLE	TED
		09G188	B WIN	IG			र 5/2007
	ROVIDER OR SUPPLIER			69	EET ADDRESS, CITY, STATE, ZIP CODE 117 MAPLE ST NW ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(X5) COMPLETION DATE
{W 100}	Based on observat review, the facility f received continuou See W195] 483.410(d)(3) SER OUTSIDE SOURC	ion, interviews and record ailed to ensure that each client s active treatment se vices. [  VICES PROVIDED WITH ES  sure that outside services	{W 1	:	Please see answer to W 195.		
{W 122}	Based on observat review, the facility is services met the no (Client #3) included. The findings included The facility failed to Client #3's needs of participate in active or lack of program 483.420 CLIENT Participate in the facility must exprotections required. This CONDITION Based on interview.	e: o ensure the day program met lue to her refusals to treatment programming and/ documentation. (See W214) ROTECTIONS	{ <b>₩</b> 1	22)	Please see answer to W 214.		
	their financial affair capabilities (See W The finding include	s to the extent of their /126).			Please see answer to W 126	i.	

A, BUILDING B. WING	I	
09G166 S. WING	R 01/25/2007	
NAME OF PROVIDER OR SUPPLIER  D C HEALTH CARE  STREET ADDRESS, CITY STATE, ZIP CODE 6917 MAPLE ST NW WASHINGTON, DC 20012	29/2007	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REFERENCED TO THE APPROPRIATE DEFICIENCY:	(X5) COMPLETION DATE	
W 122)  Continued From page 2  2006, and at the time of the survey the facility failed to ensure compliance with the aforementioned standard as documented in their plan of corrections. Therefore, non compliance with the standard results in the continued failure of the facility to protect its clients rights.  W 124)  W 124)  RIGHTS  The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the clients (Client #2) included in the sample.  According to the follow up survey on January 25, 2007, the finding includes:  Observation of the evening medication administration on January 25, 2007 at 5:57 PM revealed Client #2 received medications including Hydroxyzine HCL and Valproic Acid. Interview with the medication nurse during the medication administration revealed the medications were used to control behaviors.	ougeing	

STATEMENT OF D AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		LE CONSTRUCTION	(X3) DATE S COMPLI	
				LDING			R
	<del></del>	09G166		·~		01/2	5/2007
D C HEALTH	DER OR SUPPLIER			691	ET ADDRESS, CITY, STATE, ZIP CODE 17 MAPLE ST NW ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	O BE CROSS-	(XS) COMPLETION DATE
Interproduction of the same of	fessional (QMRI (45 PM revealed chotropic medic port Plan (BSP) RP on January not have a legal rmed consent for the use of her contionally indicate mber interested facility had imple with that processively, the facility failed to provide the provident of the contional side effect dications, and the been explained norized representation of the client and/or treatment, for one outded in the sample finding includes ervation of the rimistration on Desire and the provide ervation of the rimistration on Desire and the provide ervation of the rimistration on Desire and the provide ervation of the rimistration on Desire and the provide ervation of the rimistration on Desire and the provide ervation of the rimistration on Desire and the provide ervation of the provide ervation e	dualified Mental Retardation P) on January 27, 2007, 2006 d Client #2 received ations and had a Behavior retrieve with the 27, 2007 revealed Client #2 guardian and could not give or the use of her medications rresponding BSP. The QMRP d that Client #2 had a family in becoming her guardian and emented steps to assist Client retrieve at the time of the ailed to provide evidence of At the time of the survey, the ride evidence that Client #2 's cluding the benefits and retrieve and record retrieve to refuse treatment, to her and/or a legally retrieve.  The provide attendant and the right to refuse on, interview and record retrieve to refuse the clients (Client #2) one	{W 1		Client # 2's medications and its side effects as well as her B. explained to both the sister consent for the same was obtained to be please see attachment. A - 1	S.P. were rs and a ined.	5-16-26

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER.	A. BUI		PLE CONSTRUCTION IG	ONSTRUCTION (X3) DATE SURVEY COMPLETED	
		09G166	B, WIN	1G _			R 5/2007
	ROMOER OR SUPPLIER			6	REET ADDRESS, CITY, STATE, 2IP CODE 1917 MAPLE ST NW NASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
(W 124)	Clonazepam, Hydro Acid. Interview with the medication adm medications were to Interview with the C	exyzine HCL, and Valproic the medication nurse during ninistration revealed the used to control behaviors.	{W 1	24}	Client # 2's medications and its side effects as well as her B.S explained to both the sister consent for the same was obtained 5-16-06	S.P. were s and a	5-16-06
	:19 AM revealed Cl medications and ha BSP). Review of Cl 2006 on December the plan addressed injurious behavior, and noncompliance QMRP on December did not have a lega informed consent for or the use of her co additionally indicate family involvement, guardianship. This the review of Client Assessment date M 13, 2006 at 5:25 Ph assessment, Client capacity to make in	P) on December 11, 2006 at 9 lient #2 received psychotropic ad a Behavior Support Plan (Client #2 's BSP dated May 16, 12, 2006 at 4:51 PM revealed target behaviors of self-physical aggression, disrobing at Further interview with the er 11, 2006 revealed Client #2 I guardian and could not give or the use of her medications presponding BSP. The QMRP at that although Client #2 had she was in need of legal information was verified by #2 's Psychological flarch 29, 2006 on December M. According to the #2 "does not evidence the dependent decisions on her			Please see attachment. A - 1	42."	
{W 125}	residential placeme ongoing medical ca survey, the facility f Client #2's treatme benefits and potent the medications, ar had been explained authorized represent 483.420(a)(3) PRO RIGHTS	TECTION OF CLIENTS	. · {W 1;	25}			
	The facility must en	sure the rights of all clients.					

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU				TED .
		09G166	B. WII	NG		1	₹ 5/2007
1	PROVIDER OR SUPPLIER			6	REET ADDRESS, CITY, STATE, ZIP CODE 917 MAPLE ST NW VASHINGTON, DC 20012		_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	
(W 125)	Therefore, the faci individual clients to of the facility, and	age 5 lity must allow and encourage exercise their rights as clients as citizens of the United States, to file complaints, and the right	{W 1	25}	Please see answer to W 12	4	
	Based on observation review, the facility encouraged to exe	is not met as evidenced by: ion, interview and record failed to ensure each client was rcise their rights, for one of the 2) residing in the facility.					
{W 126}	protected by making legally sanction rep making decisions r W124)	o ensure Client #2 's rights was ag certain the client had a bresentative to assist her with regarding her treatment. (See	{W 1	26}	,		
	Therefore, the facil to manage their fin	nsure the rights of all clients. ity must allow individual clients ancial affairs and teach them ent of their capabilities.					
,	Based of interview failed to ensure clie	is not met as evidenced by: and record review, the facility ents were taught to manage is, for one of the three clients ( in the sample:			·		
	According to the fo 2007, the finding in	llow up survey on January 25, icludes:					
L	Review of the facili	ty's Plan of Corrections (POC)					

	F CORRECTION	IDENTIFICATION NUMBER:	A BUIL	DING	COMPLE	
	,	D9G166	B. WING	S		R 5/2007
	ROVIDER OR SUPPLIER			STREET AODRESS, CITY, STATE, ZIP CO 6917 MAPLE ST NW WASHINGTON, DC 20012		•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	QULD BE CROSS-	(X5) COMPLETION
(W 126)	and interview with Retardation Profes 2007 revealed that developed for Client management skills client would fill out opportunities to go check. At the time facility failed to prohad been developed by the facility failed to ensure client financial affair Client #2) included The finding included The finding included Interview with the CProfessional (QMR 11:46 AM revealed program where she Further interview Client #2 can not infinances. The QMR 11:46 AM revealed program where she further interview Client #2 can not infinances. The QMR 2 can pletting a requection of the part of the QMRP addition #2 was paid she with main office to hand staff. The QMRP igo to the bank.	the Qualified Mental sional (QMRP) on January 25, a program would be at #2 to "teach her money." The POC indicated that the a deposit slip and have to the bank and deposit her of the follow-up survey, the vide evidence that the program ed or implemented.  and record review, the facility ents were taught to manage as, for one of the three clients (in the sample:	(W 12	According to the previous #2 and others were taught the deposit slips by practic #2 needs physical assistatasks. On 02/05/07 client to the bank and deposit was be done every time they re A money management progressed developed by O.T. on 0 O.T. evaluation.  Please see attachment. But the deposit slip as outlined in money management program was informally 01/11/07 oficially docur 02/05/07. D.C.H.C. will teach above skill to client	how to fill out sing. Client nee to do the #2 was taken as made. Will sceive checks. Gram was also 2/05/07 after -1-1-2	2-5-07 engoing 02/05/07
<u> </u>		et Alexa with the Civille Oil		<u>. l </u>		

7 325 034

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN C	A GORREDHON		A. BUILD	ING	R
		09G166	B. WING		01/25/2007
	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE 6917 MAPLE ST NW	
D C REA	LIR CARE			WASHINGTON, DC 20012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS- COMPLETION
{W 126}	Continued From pa		{W 126	5)	
(W 159)	December 14, 2006 that Client #2 was been personal finances.	6 failed to provide evidence being taught to manage her	(W 159		
[,00]	RETARDATION P		•		
,	integrated, coordinate	treatment program must be ated and monitored by a ardation professional.			
	Based on observat review, the facility ' Professional (QMR	is not met as evidenced by: ion, interview and record s Qualified Mental Retardation P) failed to adequately and coordinate each client 's			
	The findings includ	<b>e</b> :			
		ed to ensure outside services ach client. (See W120)	1.	Please see answer to W 120.	
	1	ed to ensure each client's	-		
	needed compreher See W214)	nsive functional assessments. (	2.	Please see answer to W 214.	
	the Interdisciplinary client 's Individual received continuou	ed to ensure that as soon as y Team (IDT) formulated each Program Plan (IPP), clients is active treatment consisting tions and services. (See W	3.	Please see answer to W 249.	
	accomplishment of client's individual	ed to ensure data relative to the f the criteria specified in each program plan objectives were	4	Please see answer to W 252.	
{W 195}		asurable terms. (See W252) REATMENT SERVICES	{W 19	5)	

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1		PLE CONSTRUCTION	(X3) DATE SO	
			A BUI		G		R
		09G166	B. WI	NG		1	5/2007
	ROVIDER OR SUPPLIER			61	REET ADDRESS, CITY, STATE. ZIP CO 917 MAPLE ST NW VASHINGTON, DC 20012	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION SHI REFERENCED TO THE APPROPRI	DULD BE CROSS-	(¥5) COMPLETION DATE
{W 195}	Continued From pa	ġe 8	{VV 1	95}		<del></del>	
		sure that specific active requirements are met.					
	Based on observati review, the facility for treatment services to ensure each clien assessment identifi	is not met as evidenced by: on, interview, and record ailed to continuous active (See W196 and W249)); failed nt's comprehensive functional ed the specific limitations that					
	214); and failed to e accomplishment of client's individual p	s food being locked (See Wensure data relative to the the criteria specified in each program plan objectives were asurable terms (See W252).				·	et a generation
(W 196)			{W 1	00)	<del>.</del>	·	,
(** 130)		ceive a continuous active	₹ <b>00</b> 1	30)			
·	consistent impleme specialized and ger services and related subpart, that is dire (i) The acquisition the client to function	of the behaviors necessary for					
	and (ii) The prevention	or deceleration of regression otimal functional status.					. '
		s.not met as evidenced by: on, interview, and record					

	F CORRECTION	IDENTIFICATION NUMBER:	A BUI		G	COMPLE	
		09G166	B WIN	(G		1	R 5/2007
	ROVIDER OR SUPPLIER			6:	REET ADDRESS, CITY, STATE, ZIP CODE 917 MAPLE ST NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATI	.D BE CROSS-	(XS) COMPLETION DATE
{W 196}	review, the facility f a continuous active includes aggressive a program of speci	ige 9 alled to ensure clients received treatment program, which e, consistent implementation of alized and generic training, for ents (Client #3) residing in the	{W 1	96)	Please see the answer to W W 249.	214 and	
{W 214}	program objectives See W214 and W2 483.440(c)(3)(iii) IN The comprehensive	ensure Client #3's current day were being implemented. ( 49) IDIVIDUAL PROGRAM PLAN e functional assessment must specific developmental and	(W 2	14}			
	Based on interview failed to ensure ind specific objectives needs, for one of the residing in the facility According to the for 2007, the finding in Observation of Clied: 11 PM revealed the treatment area with not engaged in any	flow up survey on January 25, cludes:  nt #3 on January 25, 2007 at 1 e client seated at a table in her her coat on. The client was learning and/or recreation at		1	Client #3 was given oportuni different day programs as of An IDT Meeting was also he 01/30/07 - client # 3 started a program as of 02/08/07.	01/30/07. eld on	
•	Interview with the d client continued ref program activities. review of her availa	ervation (1:11 PM-1:30 PM), ay program staff revealed the using to participate in day This was verified through the ble data collection sheets ( 3 through December 29, 2006			F-35		•

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUII			(X3) DATE SI COMPLE	
		09G166	B. WIN				R 5/2007
i	ROVIDER OR SUPPLIER			6	REEY AODRESS, CITY, STATE, ZIP CODE 917 MAPLE ST NW VASHINGTON, DC 20012		272.007
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD 8 REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION OATE
{W 214}	and interview with the Retardation Professional (QMR). The finding includes the finding inclu	ty's Plan of Corrections (POC) he Qualified Mental sional (QMRP) on January 25, eeting was held at Client #3's nuary 19, 2007. According to eting was held to address the ted in the December 14, 2006 efusals to participate at the the time of the survey, the vide evidence that ensured to participate in active ming while at the day program t.  and record review, the facility ividual program plans stated necessary to meet the client 's e three clients (Client #2 and # ample.	(W 2	14}	Please see answer on pg. 6 & 7.  A list of items needed for client # prepared with client's input. Clie taken to the store to purchase iter well as dine out effective 01/26/0	ent is ns as	1-26-07
	<del></del>				i.		ļ

STATEMEN AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU A. BUILD	LTIPLE CONSTRUCTION	(X3) DATE S COMPLI				
;	•	09G166	B. WING	S	i	R 5/2007			
NAME OF PROVIDER OR SUPPLIER  D C HEALTH CARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)				STREET ADDRESS, CITY, STATE, ZIP CODE 6917 MAPLE ST NW WASHINGTON, DC 20012					
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SI REFERENCED TO THE APPROPR	HOULD BE CROSS-	COMPLETION DATE			
(W 214)	Review of Client #2 IPP) and further interpretation at Client #2 had been been 14, 2006 that Client #2 had been been 126)  2. Observation at Client was on a doct was conducted with client 's day program information regarding while at the day program of participate at the day further indicated head of anything and the active treatment at the information was furth with Client #3 's sis 10:14 AM. According to the client dated May placement setting client one year ago.  Continued interview review of Client #3 was in the following program of the client dated May plan, Client #3 will attended to the client dated May plan, Client #3 will attended to the client dated May plan, Client #3 will attended to the clie	's Individual Program Plan ( erview with the QMRP on a failed to provide evidence een assessed in the domain resonal finances. (See also W client #3's day program on at 12:02 PM revealed the for a program and the mounselor to ascertain a gram site. According to Client counselor, the client refuses to y program. The counselor she can not get the client to client's refusal hinders her he day program. This her verified through interview ter on December 13, 2006 at a gram site in the counselor she can not get the client to client's refusal hinders her he day program. This her verified through interview ter on December 13, 2006 at a gram to Client #3's sister, a new and was to be located for the with the counselor and s day program records on revealed a program plan for 122, 2006. According to the recommended to participate ram objectives:  end work adjustment training st 3 out of 5 days a week mplete at least 1 assigned one than 1 verbal prompt from	(W 214	Client # 3 is placed in a ne program effective 02/08/0 D.C.H.C. will continue to client # 3 at new day prog and as needed to make sur needs are met.	7. monitor ram monthly	2-8-07			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		09G166	B, WI			01/25/2007	
	D C HEALTH CARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				EET ADDRESS, CITY, STATE, ZIP CODE 117 MAPLE ST NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES . Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG	ıx I	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
{W 214}	Continued From pa	age 12	(W 2	14}		-	
W 249	several weeks in with documentation to with her programs, day program countrefused to participal not been collecting Additionally, the cospent quite a bit of on the toilet (betweed oing nothing but the programming activithe facility failed to Client #3 's refusal treatment program had been assessed	revealed that there were which there was no evidence of verify the client's participation. Continued interview with the selor revealed that the client ate daily, but the counselor had data on the refusals. Sunselor indicated that the client time in the bathroom seated that the client time in the bathroom seated that the client time in the bathroom seated that the client time. At the time of the survey, provide evidence that ensured to participate in active timing while at the day program d. DGRAM IMPLEMENTATION	w	249		,	
	formulated a client each client must re treatment program interventions and and frequency to s	erdisciplinary team has its individual program plan, eceive a continuous active in consisting of needed services in sufficient number support the achievement of the ad in the individual program plan					
	Based on staff into facility failed to en Interdisciplinary To client's Individual received continuo of needed interver	is not met as evidenced by: erview and record review, the sure that as soon as the eam (IDT) formulated each Program Plan (IPP), clients us active treatment consisting intions and services for one of #3) in the survey.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						
		09G168	B, WIN			→   3 ···	R	
NAME OF P	ROMDER OR SUPPLIER	030,00			REET ADDRESS, CITY, STATE, ZIP COD		5/2007	
D C HEALTH CARE					917 MAPLE ST NW VASHINGTON, DC 20012			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) . COMPLETION DATE	
W 249	Continued From pa The findings include	<u> </u>	W 2	49	Please see the answer to W	214 at pg.	.,	
	11 PM revealed the treatment area with not engaged in any the time of the obseluterview with the dictient continued refundamental program activities.	nt #3 on January 25, 2007 at 1 c client seated at a table in her her coat on. The client was learning and/or recreation at ervation (1:11 PM-1:30 PM), ay program staff revealed the using to participate in day This was verified through the						
	December 18, 2006 client refused).	ble data collection sheets ( through December 29, 2006				٠.,		
,	January 25, 2007 re	the data collection sheets on evealed data was being by	,					
	-Choose activity of f	recite personal information. ner choice. ment training classes 3 out of		-				
	individual program prevealed Client #3 v	s current day program plan dated May 22, 2006. vas recommended to lowing program objectives:						
	independently at lea - Client #3 will co task daily with no me staff from start to fin - Client #3 will att	end work adjustment training set 3 out of 5 days a week. mplete at least 1 assigned ore than 1 verbal prompt from sish. end at least 1 community experience bi-weekly.						
		rvey, the facility failed to rticipated in all of her						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER;	A. BUI		IPLE CONSTRUCTION	COMPLE	TED
		09G166	B. WIN	IG _			R 5/2007
	ROVIDER OR SUPPLIER			6	REET ADDRESS, CITY STATE, ZIP CODE 1817 MAPLE ST NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
W 249 (W 252)	complete an assign community outing).	ge 14 ent program objectives ( ed task and attend a GRAM DOCUMENTATION	W 2				
	Data relative to acc specified in client in	omplishment of the criteria dividual program plan documented in measurable			·		
	Based on interview failed to ensure data accomplishment of client's individual procuremented in mea	s not met as evidenced by: and record review, the facility a relative to the the criteria specified in each program plan objectives were asurable terms, for one of the #3) included in the sample.					
	The finding includes		,			· -	
	program collected of	ensure Client #3 's day lata on her programs in the required by her plan. (See W			Please see answer to W 249	<b>).</b>	
(W 263)	483.440(f)(3)(ii) PR CHANGE	OGRAM MONITORING &	{W 26	63}		. •	,
	are conducted only	uld insure that these programs with the written informed t, parents (if the client is a dian	**			<i>:</i>	
	Based on interview facility's Human Rig	s not met as evidenced by: and record review, the hts Committee (HRC) failed to med consent had been					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER.		(X2) MULTIPLÉ CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
	,	09G166	8. WI	NG			R 5/2007
	PROVIDER OR SUPPLIER			69	EET ADDRESS, CITY STATE, ZIP CODE 017 MAPLE ST NW VASHINGTON, DC 20012		
(X4) ID PRÉFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE (	BE CROSS-	(X5) COMPLETION DATE
(W 263)	obtained from the o	e behavior support plans, for ents (Clients #1 and #2)	{W 2	63}			
	s day program on I AM, revealed the c Support Plan (BSP) techniques while at 120). Interview wit Retardation Profes Client #1 's resider 2006 revealed Clie incorporated restriction. Further interpreted becamber 11, 2000 have a legal guardianship by the review of Client assessment date M 14, 2006 at 12:06 hassessment date M 14, 2006 at 12:06 hassessment, Client capacity to make in behalf with regards residential placement on the facility of th	the lead counselor at Client #1 'December 12, 2006 at 10:16 lient utilized a Behavior that incorporates restrictive the day program (See also Win the Qualified Mental sional (QMRP) and review of ontial records on December 13, and #1 also had a BSP that extive techniques while at her arrivew with the QMRP on 6 revealed Client #1 did not an and could not give informed to fher BSP. The QMRP and that Client #1 was in need of This information was verified ent #1 's Psychological March 29, 2006 on December PM. According to the set #1 "does not evidence the idependent decisions on her to treatment/habilitation, ent, financial matters and are." At the time of the called to provide evidence that committee had obtained written or either of Client #1's			Client # 1's medical and psyclaffidavits ware submitted to Dinitiate guardianship process 01/21/07. Client # 1's B.S reviewed and approv D.C.H.C./H.R.C. 7-20-0  Please see attachment. C-1-  Please see the answer on page 124.	D.D.S. to s as of S.P. was ed by	7-20-0

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M			(3) DATE SU COMPLE	
	1		B. WIN			F	₹
<u>i</u>	·	09G166	J. 7			01/25	72007
	NAME OF PROVIDER OR SUPPLIER  DIC HEALTH CARE  STREET ADDRESS, CITY, STATE, ZIP CODE 6917 MAPLE STINW WASHINGTON, DC 20012						-
(X4) ID PREFIX YAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEF	CROSS-	(X6) COMPLETION DATE
{W 263}	Acid. Interview with the medication adminedications were underview with the Corposition and medications were underview with the Corposition and has Polician addressed injunous behavior, and noncompliance plan revealed it utility. Further interview with 2006 revealed Clinguardian and could the use of her medicated that altho involvement, she with guardianship. This the review of Client Assessment date Mind assessment, Client Capacity to make in behalf with regards residential placement ongoing medical capacity, the facility fits Human Rights Corpositions were underviewed to make in the facility of th	oxyzine HCL, and Valproic in the medication nurse during ininistration revealed the ised to control behaviors. Available Mental Retardation P) on December 11, 2006 at 9 ient #2 received psychotropic id a Behavior Support Plan (lient #2's BSP dated May 16, 12, 2006 at 4:51 PM revealed target behaviors of self-physical aggression, disrobing and Additionally, review of the zed restrictive techniques.  With the QMRP on December 11 ient #2 did not have a legal not give informed consent for ications or the use of her information was verified by important in the provided information was verified by important information, and important information was verified by important information, and important information was verified by important information was	{W 2	63)	Client # 2's B.S.P. was review approved by D.C.H.C./H.R. 05/16/06.  Please see attachment - D-1-4.		05/16/06
			<del></del>				

PRINTED: 01/30/2007 FORM APPROVED

Health R	legulation Administra	ation					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G186			A. BUILDIN B. WING	6	(X3) DATE SURVEY COMPLETED R 01/25/2007		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
			LE ST NW TON, DC 2	0012			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETE DATE
(R 000)	December 11, 200 Six females with varieside in the facility were randomly self- findings of the survious at the programs, interview	was conducted from 6 through December arying degrees of disay. Three of the six resected for the sample, yey were based on a group home and at ws with staff, resident and the review of reco	ability sidents The three day ts, and	(R 000)			
(R 125)	The criminal backgeriminal history of contract worker for in all jurisdictions wemployee or contract resided within the scheck.  This Statute is not Based on the reviet failed to ensure cridisclosed the criminal employee or contract seven (7) years, in the prospective employee the criminal employee or contract the prospective employee emplo	ground check shall distine prospective employed the previous seven (within which the prospect worker has worked seven (7) years prior at met as evidenced by the of records, the GH minal background chinal history of any property worker for the previous all jurisdictions within apployee or contract worker (7) years.	sclose the oyee or (7) years, pective and or to the (MRP) ecks ospective evious or which orker has	{R 125}			
	Review of the pers 2007 revealed that criminal backgrout disclosed a seven	sonnel records on Jar the GHMRP failed to nd checks were on fill year history of all the the employee reside	ensure e and		One direct care staff (in quest background check was comple 02/02/07.  Please see attachment. £ 1-	eted on	Q:2-07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Health Regulation Administration

PRINTED: 01/30/2007 FORM APPROVED

If continuation sheet 2 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 109G166		RYCLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED R 01/25/2007							
NAME OF P	ROVIDER OR SUPPLIER	030100		ADDRESS, CITY, STATE, ZIP CODE							
D C HEALTH CARE			6917 MAF WASHING	6917 MAPLE ST NW WASHINGTON, DC 20012							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE DATE				
{R 125}	Continued From pa			(R 125)		<del></del>					
	worked for one dire	ect care staff.		;							
,	- •	۸,									
			,				,				
						-					
	 			ļ		,					
,											
			•		,						
	.,	•		,	·						
						. •					
			•	·		•					
					,						
	•										
				. ,							
						•					
Haalth Decor	ation Administration			<u> </u>		<del>.</del>					

96JC12 -